News from the MOO arena....

We have lots of news for you from the M00 arena this month! So, if you want to become informed *mooooove* on down the list! ☺

- As you are well aware by now, the ***new OASIS reporting regulation*** went into effect on 6/21/06. As a review, remember there are 3 steps to the technical portion of the OASIS:

(1) ENCODING (Entering the OASIS information in the computer)

- Effective 6/21/2006 all time points of the OASIS assessments have a uniform time frame of 30 days from the date of the assessment is completed (M0090) for encoding & submitting the data. (The 7-day lock requirement is eliminated)

(2) REVIEWING/EDITING

- Once the OASIS data are encoded, the agency will review each assessment and edit it for transmission to the State agency. (During this preparation period, the HHA must run a software application that subjects each patient data set to the CMS edit specifications and makes it transmission-ready.)
- Must accurately reflect the patient's status at the time the information is collected. The HHA must ensure the data items on its own clinical record match the encoded data that are sent to the State. It is expected that once the qualified skilled professional completes the assessment, the HHA will develop a means to ensure that the OASIS data input into the computer exactly reflect the data collected by the skilled professional.

(3) TRANSMITTING

- CMS requires the HHA electronically transmit the accurate, completed, and encoded OASIS data to the State agency within 30 days of the completion of the assessment (M0090).
- Data must be transmitted in a format that meets the requirements specified in the CMS data format standard.
- The HHA can submit a Request for Anticipated Payment (RAP) to their Regional Home Health Intermediary (RHHI) when all of the four following conditions are met:
  - After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the State
  - Once a physician's verbal orders for home care have been received and documented
  - A plan of care has been established and sent to the physician
  - The first service visit under that plan has been delivered.

(For reference regarding the HHA's options due to the new reporting regulation refer to: **https://www.qtso.com/download/OASIS%20locking%20MLN%20text%20r4.pdf.**)

- **Coding Inquiries:** Over the past few months many inquiries have come into the office regarding "coding" issues. Per CMS, "The OEC is not responsible for teaching or answering questions about coding. The RHHI is not either. The best the RHHI can advise is how or why to select the Primary diagnosis or what to list as secondary. The coding is outside of that. " It is the recommendation of CMS that agencies contact consulting firms for assistance with coding issues or you may reference the CMS website at **http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp**

- ***CMS Policy Change for Accurate Coding of Surgical Wounds***:
  Based on the current advances in wound care research, CMS will now follow the recently revised guidance on the Wound Ostomy Continence Nurses Society (WOCN) Guidance Document on "OASIS Skin and Wound Status M0 Items" (revised July 2006) regarding the lack of scientific evidence supporting the finding of the healing ridge in the assessment of surgical wounds closed by primary intention.

  CMS encourages clinicians to follow the guidance suggested in the WOCN Guidance Document on "OASIS Skin and Wound Status M0 Items" (revised July 2006) in the assessment of surgical wounds, specifically in the assessment of M0488 Status of Most Problematic (Observable) Surgical Wound. This document is found at: http://www.wocn.org.

  This policy guidance for accurate coding of surgical wounds became effective 07/27/06

- **Change in Pay Sources:** During the last several months there have been an increasing number of questions regarding payer source changes and how to handle the OASIS. To help clarify this issue for me and for the agencies I made a chart of the different scenarios of pay source changes and asked CMS to review. Please find this chart on the following page. I hope this helps clarify some questions your agency may have.

SITUATION	DISCHARGE REQUIRED	Continue OASIS Collection	*New* OASIS SOC REQUIRED
Medicare HMO/Managed Care **to** traditional Medicare	Yes	Yes	Yes
Traditional Medicare **to** Medicare HMO/Managed Care	No ***HMO may require***	Yes	No ***HMO may require***
Traditional Medi***caid*** **to** traditional Medi***care***	Yes	Yes	Yes
Traditional Medi***care*** **to** traditional Medi***caid***	Yes **Only if required by State Medicaid*	Yes	Yes **Only if required by State Medicaid*
Traditional Medicare to Private Ins	No ***Private insurance may require***	Yes	No ***Private insurance may require***
Private Ins to traditional Medicare	Yes	OASIS starts	Yes
Medicaid to Private Ins.	No ***Private insurance may*** *require*	Yes	No ***Private insurance may require***
Private Ins to Medicaid	Yes **Only if required by State Medicaid*	OASIS starts	Yes **Only if required by State Medicaid*

*** Missouri Medicaid follows Medicare rules.**

NOTE:

(1) **THESE SITUATIONS PERTAIN TO OASIS ONLY**. YOUR FISCAL INTERMEDIARY MAY REQUIRE DIFFERENT PAPER WORK. YOU WILL NEED TO CONTACT THEM FOR THAT INFORMATION.

(2) REMEMBER, THE REQUIREMENT TO DO A NEW SOC FOR COMING INTO A TRADITIONAL MEDICARE EPISODE IS SO THAT THE SOC DATE COINCIDES WITH THE 60 DAY EPISODE FOR BILLIN PROCESSES. **CMS RULES ARE ONLY FOCUSED ON MEDICARE**. OTHER INSURANCES MAY COPY MEDICARE RULES BUT CMS DOES NOT DICTATE WHAT OTHER INSURANCES REQUIRE FOR BILLING.

Revised 8/7/06

- Implementation Manual – Revised June 2006
  CMS recommends that home health agencies download the June 2006 revision of Part 1 – Implementation Manual of the OASIS User's Manual. It is recommended that each new chapter be printed so agencies can be assured that their manual is complete and accurate. The manual reflects changes from the Final Reporting Regulation, effective June 21, 2006. These zip files contain the revised cover, preface, table of contents, Chapters 1, 2, 4 (revised 06/2006), 5,8 (revised 6/2006), 9, 10, 11. The other chapters have not been revised.

  Note:
  - In Chapter 8, the date in the page footer show the revision date, about 50 pages have been revised.
  - **The information in the revised manual is effective immediately.**

  The revised OASIS manual can be printed from the OASIS Home Page… **http://www.cms.hhs.gov/oasis**.

After review of the revised OASIS Chapter 8, I found that most of the changes that CMS has made have primarily been in how you would "interpret" certain OASIS items or clarification of what is meant by the item. I have listed below some of those interpretations or clarifications as well as couple other OASIS questions that I have recently conferred with CMS about. Your agency's clinicians may already be answering these particular questions/items correctly. If not, I hope this will help clear up any questions you may have.

- *Should the comprehensive assessment and OASIS data collection be the collaborative effort of all the disciplines ordered?*
  A: One clinician is responsible for completing the comprehensive assessment. The OASIS data set and responses are incorporated into that individual's clinical documentation for the specific visit. When the clinician signs her/his name to the legal documentation, she/he verifies the accuracy of the assessment data. Therefore, **standards for clinical documentation indicate that OASIS data are collected by one person.**

  If two clinicians are seeing the patient at the same time, it is reasonable for them to confer about the interpretation of assessment data. It is also reasonable for the clinician performing the assessment to follow-up on any observations of patient status reported by other agency staff. **The actual assessment, however, is the responsibility of one clinician.**

- *Can an agency whose policy is for the nurse to conduct all comprehensive assessments do the SOC assessment before the therapist begins a therapy-only case?*
  A: An assessment done in this manner is not in compliance with the Conditions of Participation. If agency policy dictates that an RN complete the comprehensive assessment, then the RN can complete the assessment after the start of care is established by the PT. In a therapy-only case, only the

therapist's performance of a skilled (reimbursable) service can begin the episode.

- *If a patient was in the hospital on observation status on 8/20 and changed to inpatient status on 8/21 does the time spent in observation count toward the 24hour time as an acute patient before requiring a transfer OASIS to be completed? In other words, is the transfer OASIS completed on 8/21 or 8/22*?
  A: If the patient was under observation 8/20 and admitted to acute care on 8/21, then the transfer is due 8/21. As long as the patient was under observation status, the patient was under the care of the home health agency. Once admitted to the hospital, the transfer is required, date of transfer in this scenario would be 8/21. You may want to wait until you know for sure they have stayed 24 hours, but the transfer date is 8/21.

- *What OASIS data are required to be collected when the Resumption of Care (ROC) and the Follow-up (FU) assessment for recertification are within days of each other (i.e., when the patient is discharged from the inpatient facility during the last five days of a 60-day episode)?*
  A: For Medicare PPS patients: If the HHA wishes to request a payment adjustment for a Significant Change in Condition (SCIC) for the remaining days of the current payment episode, the FU assessment is completed as well as the ROC comprehensive assessment. (The ROC assessment data are used to determine the case mix for the SCIC payment adjustment, and the FU data predict the case mix for the subsequent 60-day episode.) If the HHA's decision is NOT to request a SCIC for the remaining days of the current episode, only a ROC assessment is required.

  For other patients: The ROC comprehensive assessment is required within 48 hours of the patient's return home from the inpatient facility, and the FU recertification assessment is required during the last five days of the 60-day certification period. It is possible for these two time periods to overlap as they do in this situation. When they do, a ROC is the only assessment required. This data collection will also satisfy the requirement for the FU assessment. Note that only Response 3 should be marked for M0100.

  If these two time periods do not overlap, two comprehensive assessments are required, each within the appropriate time period. One assessment will be done for the ROC, and the other will occur for the FU assessment.

- *M0063:* If a patient is a member of a Medicare HMO, another Medicare Advantage plan, or Medicare Part C, enter the Medicare number, if available. **Do not enter the HMO identification number.**

- *M0080:* Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, **only one actually completes and records the assessment.**

- *M0100: (*Response 1 – Start of care – further visits planned) On Start of Care, if a plan of care is being established, and further visits are planned. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required, **whether or not the patient will be receiving ongoing services.**

- *M0150* – This item is now limited to identifying payers to which any services are provided during the home care episode that are **included on the plan of care** and that will be billed by **your home care agency.**

- *M0175 & M0180* – For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

- *M0200* – Identifies if a change occurred **due to a new diagnosis or exacerbation of an existing diagnosis**. A physician appointment alone or a referral for home health services does **NOT** qualify as a medical or treatment regimen change. **A treatment regimen change that occurs on the day of the assessment *does* fall within the 14-day period.**

- *M0250*- Identifies whether the patient is receiving the therapies listed, whether or not the home health agency is administering the therapy. **Peritoneal Dialysis or home dialysis are not included in this item.**
- *M0420* - Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete. **The patient's treatment for pain (whether pharmacologic or nonpharmocologic treatment) must be considered when evaluating whether pain interferes with activity or movement**. Pain that is well controlled with treatment may not interfere with activity or movement at all.

- *M0430* – For pain to be considered 'intractable', the pain **must meet all three criteria listed** in the item: not be easily relieved, be present at least daily, and affect the patient's quality of life as outlined in the item wording.

- *M0440* –This item does NOT address cataract surgery of the eye or gynecological surgical procedures by a vaginal approach.

- *M0445*- Select response "no" **if a former Stage 1 or Stage 2 pressure ulcer has healed with no scar formation AND the patient has no other pressure ulcers.**

- *M0450* – Reference **www.npuap.org** for new guidance on staging of pressure ulcers. Even a previously identified Stage 4 ulcer cannot be categorized as a Stage 4 until the wound bed is visible. Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). A healed Stage 3 or Stage 4 pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. A previously healed pressure ulcer that breaks down again should be staged at its worst stage.

- *M0464, M0476, & M0488* - Reference WOCN OASIS Guidance Document revised July 2006 to identify the degree of healing evident. The web site for the WOCN is found at **http://www.wocn.org**

- *M0490* – For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. Response 0 would apply if the patient is never short of breath. Response 1 would be appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient).

- *M0680* - If the patient can get to and from the toilet during the day, but uses the commode at night for "convenience", Response 0 applies. **Tasks related to personal hygiene and management of clothing are not considered when responding to this item.**
- *M0690* – Determine the amount of assistance required for **SAFE** transfer. Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process, but they do no mean that the patient is not independent. **If ability varies between the transfer activities listed, record the level of ability applicable to the majority of those activities**.

- *M0700* – **Medical restrictions should be taken into consideration** (as with all other ADL items), as the restrictions address what the patient is able to do **SAFELY**. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for **SAFE** ambulation.

- *M0710* - **Meal "set-up"** includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc., - all of which are special adaptations of the meal for the patient.

- *M0720-* Ask the patient about the ability to plan and prepare light meals even if this task is not routinely performed. Does the patient have the cognitive ability to plan and prepare light meals. (whether or not he/she currently does this)? **The patient's own dietary requirements should be considered when evaluating the ability to plan and prepare light meals.**

- *M0790-* If **oxygen** is included in the patient's medication regimen (PRN or continuous), **consider it an inhalant medication for this item.**

- *M0810 & M0820-* Note responses to M0250 and M0500 that address the specified equipment. Observe the patient and caregiver setting up and changing the equipment. Ask them to describe the steps for monitoring and changing equipment if observation is not possible at the time of the home visit. Cognitive/mental status and functional assessments contribute to determining the response for this item.

- *M0825-* Some sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate. **If the patient needs a HIPPS code for billing purposes, a "yes" or "no" response to this item is required to generate the case mix weight rate code.**

- *M0830-* The time period that a patient can be "held" in the ER without admission can vary, so it must be verified that the patient was never actually admitted. "holds" can be longer than 23 hours; **if the patient is not admitted, then he/she has received emergent care**. **A patient who dies in the ER** is considered to have been under the care of the emergency room, not the home health agency. In this situation, **a transfer assessment**, not an assessment for "Death at Home", **should be completed**.